




Positive patient-provider relationships among transgender and nonbinary individuals in New York City

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ABSTRACT

Background: Transgender and nonbinary (TGNB) individuals have diverse health needs and may face disproportionate barriers to healthcare, including developing positive patient-provider relationships. While there is mounting evidence of gender-based stigma and discrimination in healthcare, little is known about how TGNB individuals develop positive patient-provider relationships.

Aims: To examine TGNB individuals' interactions with healthcare providers and identify main characteristics of positive patient-providers relationships.

Methods: We conducted semi-structured interviews with a purposive sample of 13 TGNB individuals in New York, NY. Interviews were transcribed verbatim and analyzed inductively for themes related to characteristics of positive and trusting relationships with healthcare providers.

Results: Participants' mean age was 30 years (IQR = 13 years) and most participants were nonwhite (n = 12, 92%). Receiving peer referrals to specific clinics or providers helped many participants find providers perceived to be competent and created initial grounds for positive patient-provider relationships. Providers with whom participants had positive relationships commonly managed primary care and gender-affirming care and relied on a network of interdisciplinary providers for other specialized care. Providers who were positively evaluated were perceived to possess in-depth clinical knowledge on the issues they were responsible for managing, including gender-affirming interventions, particularly for TGNB patients who perceived themselves to be knowledgeable about TGNB-specific care. Provider and staff cultural competence and a TGNB-affirming clinic environment were also important, particularly early in the patient-provider relationship, and if combined with TGNB clinical competence.

Discussion: Provider-focused training and education programs should combine components of TGNB clinical and cultural competence to facilitate development of positive relationships between TGNB patients and providers, thereby improving the health and wellbeing of TGNB people.



KEYWORDS

Gender identity; patient-provider relationships; patient satisfaction; qualitative research; shared decision-making

Introduction

The transgender or trans and nonbinary (TGNB) community is comprised of individuals whose gender identity differs from the sex they were assigned at birth, including individuals who identify as woman, transgender woman, trans woman, man, transgender man, trans man, or as nonbinary (outside of the binary categories of man and woman). Similar to cisgender individuals (i.e., not TGNB), TGNB individuals may have

several healthcare needs across their lifespan, including primary care, mental health services, substance use treatment, reproductive and sexual health care (e.g., fertility preservation, HIV/STI care), and, for many TGNB individuals, gender-affirming care (e.g., gender-affirming psychotherapy, hormone therapy, and surgery) (Becasen et al., 2019; Coleman et al., 2022; Edmiston et al., 2016; Gaither et al., 2022; Ziegler et al., 2020).

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However, compared to cisgender people, TGNB people face disproportionate barriers to accessing healthcare, such as being less likely to be insured and have a primary care provider, and facing stigma and discrimination in healthcare, contributing to high levels of unmet health needs in TGNB populations (Carter et al., 2020; Frank et al., 2019; Meyer et al., 2017). These challenges to accessing healthcare among TGNB individuals are compounded by excessive fragmentation, high costs, and poor coordination of care within the U.S. healthcare system (Cebul et al., 2008; Doty et al., 2020; Shrank et al., 2019) and the elevated number of uninsured or underinsured (individuals without access to comprehensive healthcare) in the country (Ayanian, 2021). Even when TGNB individuals do have access to healthcare services, healthcare providers are often not clinically capable or receptive to discussing TGNB-specific health needs, and TGNB patients often feel the need to educate their providers about their care needs (Kattari et al., 2020; Lerner et al., 2021; Safer et al., 2016).

To date, most research on TGNB people's access to healthcare focuses on stigma and discrimination in medical settings as well as barriers to accessing care, yet many health settings and providers in the U.S. are providing holistic, gender-affirming care for TGNB patients with varied health needs (Chen et al., 2016; Oransky et al., 2019; Pullen Sansfaçon et al., 2019; Reisner et al., 2015; Ziegler et al., 2020). Positive patient-provider relationships can help TGNB individuals feel supported and increase access to and satisfaction with healthcare (Inwards-Breland et al., 2019; Kearns et al., 2021; Ross et al., 2016). In turn, improved patient experience contributes to improved healthcare utilization and positive physical and mental health outcomes (Doyle et al., 2013; Larson et al., 2019), and access to gender-affirming care is associated with higher quality of life and self-esteem among TGNB individuals (Nguyen et al., 2018). However, little is known about how positive relationships between TGNB patients and providers develop and how TGNB individuals understand and characterize these relationships. A better understanding of key characteristics of positive patient-provider relationships can help inform provider training

programs and other interventions to facilitate strong working relationships between providers and TGNB individuals.

To fill this gap, we examined TGNB individuals' experiences accessing healthcare and interacting with healthcare providers in order to describe characteristics of positive working relationships with healthcare providers and explore the context in which positive patient-provider relationships are formed and thrive.

Methods

Participants

Participants were recruited through Project AFFIRM, a cohort study examining identity development and resilience among TGNB individuals in three major metropolitan areas in the U.S. Project AFFIRM recruited participants through venue-based sampling in a variety of online (e.g., social media) and offline venues (e.g., community events and groups, commercial establishments, gender-affirming healthcare clinics). We used ethnographic mapping to select recruitment sites, a technique that maps potential recruitment venues geographically while also obtaining insights into the demographic and social characteristics of TGNB individuals in these locations, allowing for recruitment of individuals from different racial, ethnic, and social backgrounds (Meyer et al., 2008; Watters & Biernacki, 1989). TGNB individuals living in New York City who reported having sex with cisgender men in the past three months were invited to participate in a sub-study focused on HIV risk, resilience, and sexual health (named AFFIRM Sex). AFFIRM Sex participants who reported being "very" or "mostly" satisfied with the healthcare they received at the clinic they usually went to when sick or in need of health advice having sex with cisgender men in the past three months, age 18 years or older, English-speaking were eligible to participate in the present study. Of the 45 participants who completed the AFFIRM Sex quantitative survey, 14 were eligible to participate in this study and 13 completed the interview; one eligible participant was scheduled by our research staff but did not show for the interview.

Procedures

Participants met with a trained interviewer at Columbia University Irving Medical Center to complete a qualitative, semi-structured, open-ended interview. Participants who reported having positive relationships with more than one provider in the past five years were instructed to choose the provider who meant the most to them for the interview (henceforth “main provider”). While interviews focused on positive relationships with participants’ main provider, participants spontaneously drew parallels between their relationship with their main provider and other patient-provider interactions and relationships. Interviews lasted 60–90 minutes, were audio-recorded, professionally transcribed, and made available to the research team as data were being collected. Preliminary discussion of initial interviews guided further data collection. Data collection took place between October 2016 and February 2017. Participants received US \$50 for participation in this study. Study procedures were approved by the Institutional Review Board, Human Subjects Committee of the New York State Psychiatric Institute/Columbia Psychiatry.

Instruments

Semi-structured interviews discussed several aspects of patient-provider relationships, including the types of concerns participants discussed with providers; positive and negative experiences with staff at the clinic where they saw their providers; factors that contributed to the patient-provider relationship being strong and positive; how gender identity influenced interactions with the provider; whether conflicts with the provider had emerged in the past and how they were managed; and how their relationship with the provider changed over time. The interview guide included 10 open-ended questions such as “Can you tell me a little bit about the healthcare provider with whom you have a strong, positive relationship?” “What makes this relationship different than other relationships you have had with healthcare providers?” and “How has your relationship with your provider grown over time?” (Supplemental Material). Each of the questions were followed by probing questions to

provide details on beliefs and experiences discussed in the interviews. Data on sociodemographic characteristics, access to health insurance, and gender affirming therapies were obtained from the AFFIRM Sex baseline quantitative survey.

Data analysis

After each interview, the interviewer wrote brief memos reflecting on topics discussed in the interviews and interactions with participants. Additionally, the research team met regularly during data collection and analysis to discuss interview transcripts and identify emerging themes. After immersion in the data, the first author developed an initial version of the codebook inductively based on close reading of a random subset of transcripts. This codebook draft was refined based on a comparison of code applications in another subset of transcripts between the first and fifth authors. Divergences in coding were resolved after discussion between coders, helping ensure dependability (Campbell et al., 2013). After four iterations, we arrived at our final codebook (i.e., codebook was able to capture all relevant data in transcripts), which contained a detailed description of codes, when to apply and not apply each code, and examples of code applications. Having finalized the codebook, the remaining transcripts were coded by the first author.

Using a descriptive phenomenological approach (Creswell, 2007; Sundler et al., 2019), coded excerpts were thematically analyzed for semantic themes related to participants’ lived experiences interacting with healthcare providers to elucidate shared meanings regarding positive patient-provider relationships. We followed the steps outlined by Braun and Clarke (2006) to identify recurrent patterns in the data with respect of the aims of this study. Thematic saturation was reached. We used Dedoose version 7.6.6 for data analysis and management.

Positionality and reflexivity

All interviews were conducted by the first author, a cisgender Latino man who was a public health graduate student in one of the participating

institutions at the time of data collection. While he had provided sexual health and HIV treatment care for sexual minority and TGNB individuals for three years preceding the interviews, his previous role as a healthcare provider was not preemptively communicated to participants to limit social desirability bias. The research team is composed of cisgender and TGNB individuals, all of whom have clinical and/or research experience working with TGNB individuals and a particular interest in studying resilience and community strengths. Our interest in strengths-based research informed this study's deliberate focus on *positive* patient-provider relationships. While the interviewer and main analyst did not keep a reflexivity journal during data collection and analysis, the research team regularly discussed interview dynamics throughout data collection and the overarching objectives of the study, which strengthens the credibility and confirmability of our findings (Lincoln & Guba, 1985).

Results

Participants' ages ranged from 18 to 52 years (median = 30, IQR = 13 years) (Table 1). Five individuals identified as transgender women, three as women, two as men, two as nonbinary, and one as genderqueer. Five participants identified as Latinx, four as multiracial, two as non-Latinx Black, one as non-Latinx white, and one Pacific Islander/Native Hawaiian. Most participants had public health insurance ($n=9$) while three had private insurance and one was uninsured. Most individuals ($n=11$) reported currently receiving gender-affirming hormone therapy and five had undergone gender-affirming surgery.

Participants reported seeing their providers for an average of 5 years (range: 10 months to 15 years). Most participants ($n=9$) saw their providers at LGBTQ-focused clinics, while four individuals attended general health clinics. Most of the participants' providers ($n=10$) were medical doctors; of these, five were primary care providers, two were endocrinologists, one was an infectious disease specialist, and one an internist. One participant could not specify the specialty of the medical doctor. The other three providers were nurses (two nurse practitioners and one registered nurse).

Table 1. Sociodemographic characteristics of the sample ($N=13$).

| | Mean (SD) |
|---|--------------|
| Age (years) | 31.3 (10.64) |
| Time seeing provider (years) | 5.0 (4.12) |
| | <i>n</i> (%) |
| Gender identity | |
| Transgender woman | 5 (38.5%) |
| Woman | 3 (23.1%) |
| Man | 2 (15.4%) |
| Nonbinary | 2 (15.4%) |
| Genderqueer | 1 (7.7%) |
| Race | |
| Latinx | 5 (38.5%) |
| Multiracial | 4 (30.8%) |
| Black | 2 (15.4%) |
| White | 1 (7.7%) |
| Pacific Islander/Native Hawaiian | 1 (7.7%) |
| Education attainment | |
| Less than high school | 5 (38.5%) |
| High school diploma/GED | 1 (7.7%) |
| Some college | 3 (23.1%) |
| College degree or higher | 4 (30.8%) |
| Health insurance status | |
| Public | 9 (69.2%) |
| Private | 3 (23.1%) |
| Uninsured | 1 (7.7%) |
| Type of clinic where sees main provider | |
| LGBTQ-focused | 9 (69.2%) |
| Generalist | 4 (30.8%) |
| Gender-affirming hormone therapy | |
| Yes, ever | 11 (84.6%) |
| Yes, currently | 11 (84.6%) |
| No | 2 (15.4%) |
| Gender-affirming surgery (ever) | 5 (38.5%) |

Through qualitative analysis, we identified four main themes related to positive patient-provider relationships: (1) initiation of the relationship; (2) scope of relationship with main provider and interdisciplinary care; (3) expectations for clinically competent care; and (4) TGNB-specific cultural competence and TGNB-affirming environments in clinics.

Initiation of the relationship

"Word of mouth" and recommendations for providers or clinics by peers was a common way through which participants initiated their relationships with providers. More than a referral, peer recommendations provided the initial grounds for positive relationships, influencing patients' attitudes toward the provider at the outset of the relationship. Therefore, positive patient-provider relationships sometimes began even before the first clinical encounter. When asked about how their relationship had changed over the years, a transgender woman commented:

I think [the relationship with my provider has not changed]. I mean, I guess because I already knew [the provider was good], people talked to me good

about him, that made it easier for me. (52 years, Latina transgender woman)

In describing how they initially found their main provider, some participants perceived quality care for TGNB individuals to be widely available in New York City, and recommended other TGNB individuals to “shop around” for providers until finding one that met their needs:

People often just keep seeing the [first] person they were assigned or the random person they just happened to go see one time, and it's totally fine if that is not a good fit. You can change providers as many times as you need to... [It's] okay to shop around. (30 years, white, genderqueer participant)

Scope of relationship with main provider and interdisciplinary care

All participants discussed gender-affirming interventions with their providers. Most participants were receiving some form of hormone therapy at the time of the interview and those not taking hormones were currently discussing the subject with their main provider. Other aspects of gender-affirming care managed by the main provider included gender-affirming surgery referral and follow-up and providing referrals or documents needed for legal name change. Some participants mentioned that discussing gender-affirming care with their main provider led to discussing other important aspects of their gender experiences:

If hormone therapy isn't going well that means your mental health probably isn't going well, that means you're probably having issues societally relating to other people. It seeps into so many areas of your life that usually in discussing hormones I'll also discuss how I'm feeling, how I'm doing day to day, you know? If things are bothering me in my relationships with family or friend or... you know? So we've talked about the whole gamut. (25 years old, multiracial, nonbinary participant)

Many participants appreciated that visits with their main providers were not mainly focused on HIV and STIs and expressed dissatisfaction with providers who assumed all TGNB individuals are at increased risk for HIV. One participant, referring to a previous provider, explained:

Don't ask only about HIV status... ask about all over-all aspects of our lives and start seeing us as human

beings with the same needs that anybody has... with the same histories, the same wants, the same needs. Like anybody else. (52 years old, Latina, transgender woman)

A few participants also described the importance of discussing other aspects of their lives besides their gender identity with their providers:

[What is meaningful about my relationship with my provider] is the way [he] talks to me. The way he reacts, interacts with me. The way he respects me. The way he tells other people to respect me, like the students [interning at the clinic]. He says, “This is a special [patient]”, because of my brain aneurysm, you know? Not because I'm trans. (38 years old, Latina, transgender woman)

While many participants valued discussing various aspects of their gender experiences and lives with main providers, the scope of clinical issues actually managed by these main providers was more limited. Most participants had a well-defined set of health conditions that were managed by their main provider and reported that discussing only these issues optimized the limited time they had together. Main providers usually managed issues such as gender-affirming and primary care (e.g., preventive services, management of chronic conditions), while other needs, such as mental health and specialized care (e.g., endocrinology, urology), were managed by other providers.

I feel that [all providers have] a place and a calling to do and a job to do. If everybody stays in their lane and mind their business, we'll be alright. I have a housing specialist, I have a Section 8 worker, I have a psychiatrist, and a therapist. Everybody has jobs. I would never, ever bring up to my medical doctor [issues that are not medical] and vice versa. (30 years old, Black woman)

More than just referring patients to specialists, main providers helped participants navigate the healthcare system, in which transphobia and discrimination were common:

He tries to connect [me to] places that he feels are trans sensitive. He always asks me when I come back from that appointment how I was treated. He has always told me if there's any way that I feel that I wasn't comfortable with how they treated me, to let him know. For example, when he sent me for the breast exam, because they found a little lump in one of my breasts, he immediately asked me how I

felt. Like, you know, how they treated me, if I was comfortable and all of that... He's got a good network, people that he feels will treat you with respect because of your gender identity. (52 years old, Latina, transgender woman)

Additionally, main providers also helped address participants' complaints related to clinic procedures (e.g., binary intake forms) and staff (e.g., incorrect use of pronouns), particularly at clinics not specializing in care for LGB or TGNB patients:

[Clinic staff] have my legal name [on file] still, so they [ask], "What's your name?" and I tell them, "You know what's my name!" But aside from that, [the clinic is] great, but that was because I voiced my concern with the doctor. He, I guess, spoke with the staff. (25 years old, multiracial, nonbinary participant)

Expectations for clinically competent care

For most participants, TGNB clinical competence (i.e., being knowledgeable and able to manage health concerns related to gender identity and expression, including and especially medical management of gender-affirming healthcare) (Clark et al., 2017) was key to developing strong, positive relationships with providers. Participants underscored that they did not want to have to "educate" their providers and therefore having providers clinically capable of addressing their health needs, including gender-affirming care needs, was important:

I think [my provider] really fulfilled what I want from my healthcare provider, which is the specific medical knowledge and specialty. Of course, I want them to be competent in basic trans things, and respectful, and all that, but I don't need social support or that kind of thing as much. Or I get that from other providers or a therapist. And she's not cold, but she's not the warm and fuzziest provider I've ever had. But for our relationship that was totally fine because I just needed her to be super smart [about my gender-affirming care] and she was. (30 years old, white, genderqueer participant)

Previous negative experiences in healthcare in which participants perceived providers to be incapable of managing gender-affirming treatments led many patients to build their own knowledge about gender-affirming care. For some participants, their knowledge about gender-affirming therapies was described as empowering, prompting opportunities

for shared decision-making with clinically competent providers:

[My provider] loves the fact that my knowledge is so high. I'm like, "Why can't I do this? What about this?" I told him about Tamoxifen which is an estrogen blocker and he was like, "Oh, my God, I've never heard anyone say that in New York before. How did you come up with that?" And I was like, "Dude, it's an E- [estrogen] blocker. Hello." He was impressed with my knowledge. (21 years old, multiracial man)

However, in some instances, a participant's knowledge and expectations related to gender-affirming care conflicted with their main provider's clinical judgment. In those situations, conflict resolution and deciding to adhere to providers' recommendations depended on participant's trust in their provider's clinical knowledge and expertise:

I've heard from girls that are taking three different types of estrogen and their doctors don't know because they are trusting their natural instincts over their [provider's] and I think that that's a lack of trust with their doctor... They think that they know better than the doctor that they're with and I think that's a huge issue because this [provider], if they know what they're talking about, they've had trainings, they have degrees, they've probably studied this. They need to have studied this because [the provider is] taking my life in [their] hands and giving me a medication that could have adverse effects long-term. (22 years old, Latina woman)

Other strategies to resolve potential patient-provider conflicts around management of gender-affirming care included open communication with the main provider and other health professionals to develop shared expectations and goals for gender transition:

If you don't have a realistic view of transitioning, that would be a problem... I think part of the reason also why I like going to that institution is because prior to me seeing my doctor, [the clinic] actually provided an orientation on transitioning, "Is this the right path for you?"... So at least during the orientation, hopefully you won't have [too] high expectations for transition. (36 years old, Pacific Islander/Native Hawaiian, transgender woman)

In some instances, when patients and main providers could not resolve conflicts stemming from divergences between patients' expectations for gender-affirming care and providers' clinical judgment, other providers were called upon for support:

[My provider and I decided to] talk to someone else who is more knowledgeable about hormones, because [the secondary provider] is an endocrinologist, and see what's going on. So it wasn't "I'm going to find a different provider," just "let's get another opinion on this." (23 years old, Latino man)

TGNB-specific cultural competence and TGNB-affirming environments

TGNB-specific cultural competence also facilitated positive patient-provider relationships—particularly when combined with perceived clinical competence. TGNB cultural competence involves understanding and using appropriate terminology and language when interacting with TGNB individuals, understanding broader structural and community-level factors that are relevant to the TGNB community (e.g., transphobia and TGNB community resilience), and affirming individuals' gender identities and experiences through actions (Wilkinson, 2014). Many participants said that to feel comfortable discussing their health needs with their provider, in addition to clinical competence, providers needed to demonstrate having TGNB cultural competence, such as through listening to and understanding participants' broader experiences and concerns:

I think the thing I value the most is her vast knowledge of things that are specifically related to LGBT lives, you know, and coupled with her vast medical knowledge. I trust her to know what is available in terms of treatments or procedures or the best way to go forward with things. I feel she knows what she's talking about, you know? So yeah, it's both... it's the familiarity in the way that she is relating to me... but also I feel she asks questions about my practices that tell me that she knows what she's talking about. There seems to be a practical knowledge and a familiar knowledge about the LGBTQ community as a whole. (35 years old, multiracial, nonbinary participant)

All of the main providers discussed by participants were cisgender and therefore limited in their ability to understand TGNB patients' lived experiences. However, participants felt validated, understood, and cared for when providers engaged in active listening and fostered shared decision-making, demonstrating respect for participants' experiences and needs:

I think [being sensitive to transgender health issues] just meant that he was an ally... He wasn't trans,

he was just a general doctor who had training in a different knowledge of hormones, but it was the way he spoke to me, was very respectful... And a lot of people assume you have to be a trans person to know how to speak to a trans person, but really it just involves listening, more than anything. And I think he was prepared to listen to my needs and to what my timeline looked like, if I wanted [gender affirming] surgery or if I was having problems with hormones... He wanted to know and he was ready to listen. (22 years old, Latina woman)

Some participants felt that a LGBTQ-identified provider would develop cultural competence more easily and was better positioned to understand their needs and not stigmatize TGNB patients than a cisgender, straight-identified provider. When describing how their provider's queer identity would affect their patient-provider relationship, a participant explained:

I guess it takes down that suspicion of being treated as a token. Or as a novelty, as a science experiment, what have you. And I think I feel much more suspicious of that from straight and cis people, obviously, and I just feel a little more comfort that [the provider is] not thinking of me as a novelty if they're a queer person. (30 years old, white, genderqueer participant)

Participants also discussed the importance of culturally competent staff and TGNB-affirming physical environments (e.g., gender-neutral bathrooms, LGBTQ-specific decoration, printouts targeting health issues that are common among TGNB individuals). Although most participants thought it was important to train clinic staff in how to affirm TGNB patients, TGNB-affirming physical environments were considered secondary to positive clinical interactions. For example, some participants reported that TGNB-affirming environments contributed to creating "safe spaces" for TGNB individuals, but receiving quality care was of greater importance:

I think they have an LGBT flag [at the clinic]... I feel like the purpose of a health community center is just to provide healthcare and however they can do that best, that's the most important to me. [But] you know, it's affirming to see an LGBT flag, when I go in and I know it's a safe space... It's nice if [the flag is] there but I'm more concerned that the healthcare place does its job. (25 years old, multiracial, nonbinary participant)

The importance attributed to TGNB-affirming environments varied across participants,

depending on participants' comfort with gender presentation and concerns about misgendering. For example, participants whose gender presentations aligned with their gender identities and those expressing less concern about being misgendered perceived TGNB-affirming environments at the clinic to be less crucial for quality care. As one participant explained:

[A TGNB-affirming environment at the clinic] isn't quite as important to me now mostly because I'm comfortable with my gender presentation and I generally don't have to worry about being misgendered most of the time, but definitely when I was early in transition and I wasn't as confident, it was a huge relief [to be in a gender-affirming environment]. (23 years old, Latino man)

Likewise, a few participants emphasized that as they developed trust in the clinic and the provider, the importance of TGNB-affirming environments decreased and the importance of patient-provider relationships increased:

I think when you're a new client, or you're still making up your mind about a place, the environment – stuff like posters, pamphlets [featuring TGNB individuals] – makes a big difference. When you're [thinking]: Is this a place that I like or not? And, honestly, a lot of the time you spend in a doctor's office is in the waiting room, so you sit there and you're nervous and you look around at all this stuff and if the stuff you're looking at is reassuring, I think that makes a big difference in the very beginning. But once you're used to a place, it starts to matter less because you're already attached to your provider or the nurses there. (30 years old, white, genderqueer participant)

Discussion

This exploratory qualitative study with TGNB individuals in New York City contributes to a growing body of literature on health services for gender minority populations. Our findings indicate the importance of providers combining clinical (e.g., technical knowledge about health issues relevant to TGNB individuals) and cultural competence (i.e., affirming language, supportive attitudes and interactions), in developing positive relationships with TGNB patients (White-Hughto et al., 2017). In our study, TGNB cultural competence and TGNB-affirming environments were

particularly important at the beginning of patient-provider relationships, suggesting that cultural competence and TGNB-affirming environments may be necessary to initiate—but not sufficient to sustain—fruitful relationships with providers. Similar to previous research, our study highlights that providers must also be clinically competent and up-to-date on the management of general and TGNB-specific health concerns, thereby alleviating TGNB patients' concerns about having to educate their providers about how to manage their health needs (Bauer et al., 2009; Dewey, 2008; Kattari et al., 2021; Lerner et al., 2021; Poteat et al., 2013; Ross et al., 2016; Safer et al., 2016).

Potential areas for training programs to bolster provider clinical competence we identified in our study included support in assessing what gender-affirming interventions are appropriate, clinically managing gender-affirming interventions (e.g., hormone therapy), and evaluating when to involve other professionals (e.g., specialized providers, surgeons, social workers, etc.). Existing studies of training modules for providers have shown significant short-term improvements in clinical and cultural competence in TGNB care (Braun et al., 2017; Dubin et al., 2018; Kidd et al., 2016; Lacombe-Duncan et al., 2021; Lelutiu-Weinberger et al., 2016; White-Hughto et al., 2017). However, evidence for long-term efficacy of training and education programs is lacking, a gap which should be addressed by future research.

Previous research has also highlighted the importance of the interrelationships between clinical and cultural competence. Lack of clinical competence and training on TGNB-specific health issues contributes to failing to recognize social and medical needs and concerns of TGNB patients as legitimate and worthy of clinical management (Kearns et al., 2021; Poteat et al., 2013). Additionally, providers with limited awareness of TGNB communities and their health needs and insufficient TGNB cultural competence may not be motivated to access the education needed to provide good quality care (Bauer et al., 2009; Stroumsa et al., 2019). Insufficient TGNB cultural competence also hinders the development of competence in understanding structural factors

(e.g., stigma) that sustain deficiencies in medical education in TGNB health (Metzl & Hansen, 2014; Wilkinson, 2014). Both clinical and cultural competence are important in shared decision-making, allowing for providers to share accurate information with patients while also engaging in active listening of their patients' needs and expectations, toward shared therapeutic decisions (Charles et al., 1999; Clark et al., 2021; Elwyn et al., 2000). Therefore, provider-focused training and education should incorporate components to promote specific clinical knowledge about TGNB health needs and TGNB cultural competence and foster shared decision-making in care, decreasing gender-related discrimination in healthcare and elevating quality of care for TGNB patients (Radix & Maingi, 2018).

Bolstering provider clinical and cultural competence and shared decision-making in care partly rely on changes in the environment of the clinic and the health system at large. For example, despite national pushes for systematic collection of gender identity information in intake forms, implementation of this measure in the U.S. has lagged (Cruz & Paine, 2021; Grasso et al., 2019). Routine collection of gender identity data accounting for TGNB identities holds promise to facilitate and guide patient-provider communication about gender identity and expression, thus promoting provider TGNB cultural competence over time. Other organizational changes to medical history forms that account for non-cis-heteronormative experiences, local policies against gender-based discrimination, and institutional partnerships with community-based organizations working toward TGNB health and rights can also create environments more conducive to development of provider clinical and cultural competence (Goldhammer et al., 2018; Goldhammer et al., 2021). Moreover, shared decision-making can be promoted by allotting sufficient time for medical visits, ensuring appropriate physical space and limiting wait times in clinics, and creating financial incentives for providers (Altman et al., 2019; Joseph-Williams et al., 2014). Future investigations should evaluate whether coupling provider-focused interventions to promote clinical and cultural competence with changes in organizational aspects of health services and systems

leads to optimized impact in promoting positive TGNB healthcare experiences and improved access to gender-affirming care.

TGNB individuals may develop extensive clinical knowledge about their health needs based on previous experiences with clinicians, trial and error, peers' experiences, reading scholarly articles, and internet-based sources such as online forums (Dewey, 2008; Halloran et al., in press; Hobaica et al., 2019). Beyond greater access to information, this knowledge-building process can make patients more empowered and better prepared to participate in healthcare decisions meaningfully (Joseph-Williams et al., 2014; Joseph-Williams et al., 2014). While active engagement of patients in their own care may challenge traditional patient-provider power dynamics and lead to conflicts (Dewey, 2008; Peitzmeier et al., 2020; Poteat et al., 2013; Willis et al., 2016), we show that it may also create opportunities for positive patient-provider interactions and shared decision-making (Paine, 2021). Tensions stemming from different opinions and expectations related to management of gender-affirming care between patients and providers, for example, were eased by trust in the clinical competence of the provider and shared clinical decision-making with respect to therapeutic goals and interventions. Our findings therefore corroborate research that has linked shared decision-making to provision of quality, holistic care, and increased patient satisfaction (Charles et al., 1999; Clark et al., 2021; Shay & Lafata, 2015; van de Grift et al., 2018).

TGNB individuals may be in need of a variety of mental health, primary and gender-affirming care and other health services, including urology, endocrinology, fertility preservation and assisted reproductive care (Becasen et al., 2019; Chen et al., 2016; Coleman et al., 2022; Edmiston et al., 2016; Gaither et al., 2022; Wylie et al., 2016). Given the complexity of these health needs, which may not be able to be managed in primary care, holistic care for TGNB individuals should involve interdisciplinary teams (Chen et al., 2016; Wylie et al., 2016; Ziegler et al., 2020). Our findings suggest that TGNB individuals' main providers can help maintain positive relationships with TGNB patients by assisting coordination of interdisciplinary

care—for example, referring patients to TGNB-affirming providers. This coordinating role of providers may be particularly important in the U.S., where access to care is shaped by characteristics of health insurance (e.g., institutionally or publicly sponsored) (Gutierrez, 2018) and communication across medical and social service providers is not standardized and can be particularly challenging (Doty et al., 2020). Coordinating care also gives providers opportunities to mediate situations in which participants felt stigmatized or treated disrespectfully by other providers or staff. Indeed, conflict resolution can promote patient-centered care and strengthen patient-provider relationships (Hargraves et al., 2020).

The role of providers helping patients navigate interactions within a healthcare system that remains largely ill-prepared and insensitive was particularly important at early stages of gender identity development, especially for TGNB individuals receiving care at clinics not focused on LGBTQ care. LGBTQ-focused clinics often have specific culture, policies, training, and services geared toward caring for TGNB patients, including having TGNB and LGB-identified providers and staff, which facilitate the creation of safe spaces for TGNB patients (Bishop et al., 2022; Chen et al., 2016; Reisner et al., 2015; Reisner et al., 2016). In contrast, non-specialized clinics may be less likely to foster TGNB cultural competence among staff and providers on the interdisciplinary team, even if the main provider is clinically and culturally competent (Teti et al., 2021).

As participants gained experience living in a gender role congruent with their identity, concerns related to culturally insensitive staff and clinic environments seemed to diminish. Changes in perceived importance of TGNB-affirming staff and environments may reflect TGNB changes in gender presentation and identity development over time. Changes in gender presentation (e.g., as a result of longer-term hormone use) and greater comfort with self may lead to reduced instances of misgendering and decreased anxiety in accessing healthcare (Kcomt et al., 2020; Paine, 2018). Moreover, after coming out, TGNB individuals may eventually reach stages in their identity development process in which their TGNB identity is integrated with other aspects of the self. In these

stages, TGNB individuals may experience higher self-acceptance and resilience, and tend to be less concerned about identity labels and misgendering (Bockting & Coleman, 2016). Identity development may also bring about decreased anxiety related to interactions in healthcare settings as individuals develop more resilience in interacting with largely cis-normative, binary institutions, such as healthcare, as a TGNB person (Budge et al., 2018; Hendricks & Testa, 2012). Future research should examine how identity development impacts the relative importance attributed to clinical and cultural competence in healthcare encounters and how healthcare services may provide quality care for TGNB individuals across their lifespan.

Our study has several limitations. Although our sample was racially and ethnically diverse, it was limited to TGNB individuals in New York City who have sex with cisgender men and were part of a larger cohort study. As such, our findings are unlikely to represent the experiences of TGNB individuals in different contexts—especially non-urban settings—with less access to TGNB-competent care (Teti et al., 2021). Moreover, we instructed participants to respond to interview questions based only on their most meaningful patient-provider relationship in the past five years and most providers discussed in the interviews were directly managing hormone therapy, highlighting the salience of gender-affirming therapies for many TGNB individuals. Future research should examine positive relationships with different types of healthcare providers, including those not involved in gender-affirming medical interventions, and challenges and facilitators to developing and maintaining positive relationships within an interdisciplinary care framework. Moreover, data were collected in 2016 and 2017, and healthcare experiences of TGNB individuals may have changed since then, accompanying progresses and setbacks in the sociopolitical climate around TGNB rights and healthcare access in the period (Bockting et al., 2020). We encourage further studies to continue to elucidate patient-provider relationships and interactions among TGNB individual through a strengths-based prism. Additionally, though examining differences in healthcare interactions across gender and racial

and ethnic identities was beyond the scope of this study, since healthcare access and experiences among TGNB often vary across multiple dimensions of social identity, future studies with an intersectional approach may bolster efforts to design interventions to improve TGNB healthcare experiences (Howard et al., 2019; Kattari et al., 2021; Kcomt et al., 2020; Paine, 2021; Seelman & Poteat, 2020). Finally, data collection did not take place in healthcare contexts and we did not observe patient-provider interactions in loco, which would have provided thicker descriptions of patient-provider interactions and enhanced trustworthiness of findings (Lincoln & Guba, 1985). Future research would be strengthened by the participation of dyadic patient-provider pairs, including examining patient-provider interactions in healthcare settings. This would be particularly relevant to investigate management of conflicts and shared decision-making processes in patient-provider relationships.

Conclusions

Existing research on interactions between medical providers and TGNB patients has focused on stigma and discrimination in healthcare settings and several studies have identified stigma as a social determinant of health disparities among TGNB populations (Bränström & Pachankis, 2021; Drabish & Theeke, 2022; Hendricks & Testa, 2012; Valente et al., 2022; White-Hughto et al., 2015). Despite barriers to accessing quality care, our study in a major U.S. urban center indicates that TGNB individuals have also succeeded in establishing and maintaining strong, positive relationships with healthcare providers. Given the importance of clinical and cultural competence in TGNB-specific care within the interdisciplinary team, a growing body of literature calls for training providers about TGNB patients' medical and social needs (American Psychological Association, 2015; Kosman et al., 2019; Park & Katz, 2018; Pratt-Chapman et al., 2022). Existing initiatives include the development of specific coursework or training modules on gender and sexuality in healthcare for medical students (Braun et al., 2017; Coleman, 2014; Dubin et al., 2018; Vance et al., 2017), residents (Dubin et al., 2018; Kidd et al.,

2016), and licensed providers (Lelutiu-Weinberger et al., 2016; White-Hughto et al., 2017). Others propose integrating education on gender, sexuality, and LGBTQ and TGNB health throughout clinical training (rather than in standalone modules) (Shindel et al., 2016) and periodic clinical and cultural competence trainings upon hiring of new staff and providers (Goldberg et al., 2018; Reisner et al., 2015). However, most of these initiatives have yet to be systematically evaluated for their long-term impact on knowledge, clinical expertise, and cultural competence among providers and satisfaction with care and other clinical outcomes among TGNB patients. Therefore, how education and training on clinical and cultural competence in TGNB health should be implemented remains unclear. Findings from our study emphasize that clinical expertise, including technical knowledge about gender-affirming care, is critical in addition to cultural competence, and the availability of such specialty training remains limited. In addition, training and education interventions should be coupled with structural and organizational changes in health clinics and systems for sustained impact and decreased reliance on individual providers. Broader advocacy for TGNB rights and access to health may also create a societal environment more amenable to specific training programs to bolster clinical and cultural competence. Future research should examine and evaluate the impact of different multi-level interventions on improving quality of care provided for TGNB individuals.

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